MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

01639

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: La Plata md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Hours
Hospital, Institution, or street address where death occurred: Physic mem Hospital
How long in hospital or institution? 7 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Charles
City or town: Nr Waldorf md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Nanny B. Anderson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Robert
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 16-1881

8. AGE: Years	Months	Days	If less than one day
64	0	30	..... hrs. ..... min.

9. Birthplace: Salem V.a (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Henry Mowles
13. Birthplace: Floyd Co Va

MOTHER
14. Maiden name: Susan Alley
15. Birthplace: Floyd Co Va

16. Informant: Robert Anderson
Address: Waldorf md

17. Burial (Burial, cremation, or removal. Which) Date thereof 2-17-45 (month) (day) (year)
Cemetery or crematory: St Paul Piney
Location: Nr Waldorf md
18. Funeral director: Hamilton Peyton
Address: Waldorf md

19. 2-16 (Date rec'd by registrar) 19 45 Julia H. Pasey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 15 19 45 at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 45, to 2-15 19 45 and that I last saw h[illegible] alive on 2-15 19 45

Immediate cause of death	DURATION
Congestive Heart Failure	1-13-45
Due to	
Due to Hypertension	7
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] Edelen M.D.
M. D. or other
Address: La Plata Md Date signed 2-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01640

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: La Plata, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Physicians Memorial
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Popes Creek, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Day

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	M

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) —

8. AGE: Years 65 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Chas. Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden name —
15. Birthplace —

16. Informant: Hosp. Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/7/45 (month) (day) (year)
Cemetery or crematory: St. Mary's
Location: Newport, Md

18. Funeral director: Hunter & Ryon
Address: Waldorf, Md.

19. Feb. 6 1945 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 - 4 1945, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 - 1 1945, to 2 - 4 1945
and that I last saw h[illegible] alive on 2 - 4 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2-1-45
Due to: Generalized Arterio-Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: La Plata Md. Date signed 2-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01641

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 1/2 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Nellie Decker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Dewitt Decker
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 13, 1869

8. AGE: Years: 76 | Months: 0 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: England
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER
12. Name: Horton
13. Birthplace: England.

MOTHER
14. Maiden name: Unknown
15. Birthplace: England.

16. Informant: Martin P. Bird
Address: Indian Head, Md

17. Burial / Removal (Burial, cremation, or removal? Which?) Date thereof Feb 10th 1945 (month) (day) (year)
Cemetery or crematory
Location: Washington D.C.

18. Funeral director: W. W. Chambers Co
Address: 3012 M st nw Washington. D. C.

19. 2-10 1945 (Date rec'd by registrar) Julia H Passey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10 1945, at 11A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 9. 1945 to Feb 10 1945
and that I last saw her alive on Feb. 9 1945

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to: Upper Respiratory Infection	1 week.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Frank L. Susano M.D.
M. D. or other
Address: Indian Head. Md Date signed 2/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of residence of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

01642

Reg. Dist. No. 105

FILE C 94 MAY 11 1945

1. PLACE OF DEATH:
County Charles
City or town Rural Welcome
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town Welcome (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. --
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ~~Thomas~~ John Thomas Hindle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife Cordelia Hindle
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1871

8. AGE:

Years	Months	Days	If less than one day
73	5	12	hrs. min.

9. Birthplace Welcome, Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name William T. Hindle
13. Birthplace Chas. Co. Md
MOTHER 14. Maiden name Ann Mattingly
15. Birthplace Chas. Co. Md.
16. Informant Cordelia Hindle
Address Welcome, Md
17. Burial (Burial, cremation, or removal) (Which?) Date thereof 3/2/45 (month) (day) (year)
Cemetery or crematory St. Ignatius
Location Hard Fork, Md
18. Funeral director Hunt & Ryan
Address Waldorf, Md.
19. Mar. 2 1945 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1945 at 8 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-20 1941 to 2-27 1945
and that I last saw him alive on 2-26 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2-24-45
Due to Generalized Arterio Sclerosis & Arterio Sclerotic Heart Disease	10-20-41
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D.
Address LaPlata, Md. M. D. or other
Date signed 3-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75

01643

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:
County: Charles
City or town: Pisgah
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME George R. Simmons

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Cecelia Simms
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): May 19 1873

8. AGE:

Years	Months	Days	If less than one day
71	8	14	...hrs. ...min.

9. Birthplace: Welcome Chas Co. Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: James Simms
13. Birthplace: Charles Co. Md.

MOTHER
14. Maiden name: Caroline Jackson
15. Birthplace: Charles Co. Md.

16. Informant: Clarence Simms
Address: Welcome Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5 1945 (month) (day) (year)
Cemetery or crematory: Catholic
Location: Hill Top Md

18. Funeral director: Stanley Remy
Address: Pisgah Md.

19. Feb. 3 1945 (Date rec'd by registrar) Mary Lyttleton Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 1945 at 5-15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1944 to Feb. 2 1945 and that I last saw him alive on Jan. 28 1945

Immediate cause of death	DURATION
Anemia	
Exhaustion	
Due to: Amyloid Spleen	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Pickrell M. D. or other
Address: Pomonkey Md. Date signed: Feb. 3 1945

(M)

MARGIN RESERVED FOR BINDING

(I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8-e)

CERTIFICATE OF DEATH

01644

Reg. Dist. No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: Bryantown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Bryantown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Richard Dement Jr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 27 1944

8. AGE: Years: 1 | Months: 7 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Sergeant

11. Industry or business: Infant

FATHER
12. Name: Jas. Richard Dement Sr
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Lillian Queen
15. Birthplace: Maryland

16. Informant: Mrs. J. R. Dement Sr.
Address: Bryantown Md

17. Burial, cremation, or removal. Which? Burial (Month) 2 (Day) 7 (Year) 45
Cemetery or crematory: Sacred Heart Ch
Location: LaPlata Md

18. Funeral director: Penn & Baker
Address: Waldorf Md

19. 2-28-1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/28/45 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/28/45 to 2/28/45
and that I last saw deceased on 2/28/45

Immediate cause of death	DURATION
Acute Cardiac Dilitation	
Due to	
Due to [redacted]	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Dep Coroner
M. D. or other
Address: Hughesville Md — Date signed 2/28/45

Evidence for change of age of deceased is shown on

FILM No. G 9 4 APR 13 1945

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

01645

CERTIFICATE OF DEATH

Reg. Dist. No. 105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Charles
City or town: Rock Point (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred: Rock Point
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Rock Point, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. — (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Williams

3.(b) Social Security Number: —

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 5-16-60
8. AGE: Years 84 ~~85~~ Months Days If less than one day ... hrs. ... min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Retired Gardener
11. Industry or business

FATHER
12. Name: Axel Williams
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: "

16. Informant: Charles E. Williams
Address: 1756 Lang Place N.E. Wash.
17. Burial Date thereof: 2-5-45 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Prospect Hill
Location: Washington D.C.
18. Funeral director: Hunt & Ryon
Address: Waldorf Md.
19. 2/21 1945 M. E. Moran
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 1, 1945 at 12:30 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on Feb. 1, 1945 ~~to~~ ~~19~~ and that I ~~last~~ saw him ~~alive~~ on Feb. 1, 1945

	DURATION
Immediate cause of death: acute coronary occlusion	5 min.
Due to: Coronary artery disease	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: James T. Mackaway, M.D. Deputy Medical Examiner
M. D. or other
Address: La Plata, Md. Date signed 2-1-45

VS A15

(1)

(T)